TDH

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.tdh.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

TBIAC

BRAIN INJURY SCREENING

If a person/child has experienced a blow to the head, with or without a loss of consciousness, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered. This is a brief screening device for traumatic or acquired brain injury to evaluate whether a person/child may have experienced a brain injury. Nearly 1 million brain injuries occur every year in the United States, but some people may not realize that they experienced a brain injury. Correctly evaluating a person/child for brain injury helps determine their service needs.

Name (Last)_____ (First) _____ (MI) _____

Program ID, if any _____ If child, school grade level _____

DOB ☐☐-☐☐-☐☐☐☐ SSN, with consent ☐☐☐-☐☐-☐☐☐

Gender ☐M ☐F Known Injury? ☐Yes ☐No Date of Injury ☐☐-☐☐-☐☐☐☐ Lost Consciousness? ☐Yes ☐No

If Loss of Consciousness, Duration (check only one) ☐ None ☐ Less than 1 minute ☐ 1-15 minutes

☐ 16 minutes to 1 hour ☐ 1 hour to 24 hours ☐ 25 hours to 7 days ☐ 8 days to one month

☐ 1 to 3 months ☐ 4 to 12 months ☐ More than one year ☐ Unknown

Present Mobility ☐ Bedridden ☐ Wheelchair (frequent) ☐ Wheelchair (infrequent)

☐ Walks with assistance ☐ Walks without assistance

INJURY HISTORY

		If Yes, Comments such as: When? or How Oft
Has the person/child ever --		
Had a concussion?	☐ Yes ☐ No	_____
Been in a car/van/truck/bus crash?	☐ Yes ☐ No	_____
Had "whip lash" injury?	☐ Yes ☐ No	_____
Been in a motorcycle or an all-terrain vehicle crash?	☐ Yes ☐ No	_____
As a pedestrian, been hit by a vehicle?	☐ Yes ☐ No	_____
Has the person/child ever been hit on the head --		
By equipment or a falling object?	☐ Yes ☐ No	_____
Has the person/child ever been hit on the head when falling –		
On a level surface?	☐ Yes ☐ No	_____
Down stairs?	☐ Yes ☐ No	_____
From a high place?	☐ Yes ☐ No	_____
During a fainting spell?	☐ Yes ☐ No	_____
As a result of using drugs or alcohol?	☐ Yes ☐ No	_____
Has the person/child ever been hit on the head during a sports activity --		
While bicycling, roller blading or skate boarding?	☐ Yes ☐ No	_____
While horseback riding, skiing or snow boarding?	☐ Yes ☐ No	_____
In team sports (football, baseball, basketball, soccer)?	☐ Yes ☐ No	_____
While swimming or diving into water?	☐ Yes ☐ No	_____
Has the person/child ever experienced a blow to the head as a result of --		
Assault or mugging?	☐ Yes ☐ No	_____
Fighting?	☐ Yes ☐ No	_____
Physical abuse?	☐ Yes ☐ No	_____
Being shaken as a baby?	☐ Yes ☐ No	_____
Other cause of a blow to the head?	☐ Yes ☐ No	Specify _____

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BRAIN INJURY SCREENING CONTINUED

MEDICAL HISTORY Has the person/child ever been in the hospital, seen in an emergency room or by a doctor for any of the following reasons?

Concussion	☐ Yes ☐ No	Fracture of the head, neck or face	☐ Yes ☐ No
Seizure(s)	☐ Yes ☐ No	Near drowning	☐ Yes ☐ No
Episode(s) of Anoxia	☐ Yes ☐ No	Loss of consciousness	☐ Yes ☐ No
Electrical power injury	☐ Yes ☐ No	Lightening strike	☐ Yes ☐ No
Gun shot injury to the head	☐ Yes ☐ No	Other penetrating injury to the head	☐ Yes ☐ No
Brain infection or tumor	☐ Yes ☐ No	Stroke or brain hemorrhage	☐ Yes ☐ No
Other medical emergency	☐ Yes ☐ No	Specify _____	

If a person/child has one or more of these experiences, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered.

PROBLEMS OR DIFFICULTIES EXPERIENCED IN DAILY LIVING

Trouble staying awake?	☐ Yes ☐ No	Difficulty concentrating?	☐ Yes ☐ No
Trouble sleeping?	☐ Yes ☐ No	Problems with memory?	☐ Yes ☐ No
Frequent headaches?	☐ Yes ☐ No	Difficulty reading, writing, or calculating?	☐ Yes ☐ No
Dizziness?	☐ Yes ☐ No		
Blackouts?	☐ Yes ☐ No	Difficulty performing assignments at school or work?	☐ Yes ☐ No
Seizures?	☐ Yes ☐ No		
Problems with balance?	☐ Yes ☐ No	Difficulty with physical coordination?	☐ Yes ☐ No
Difficulty problem solving?	☐ Yes ☐ No	Blurred or double vision?	☐ Yes ☐ No
Unusual anxiety?	☐ Yes ☐ No	Difficulty with relationships?	☐ Yes ☐ No
Depression?	☐ Yes ☐ No	Unusual fatigue?	☐ Yes ☐ No
Difficulty planning events?	☐ Yes ☐ No	Difficulty following instructions?	☐ Yes ☐ No
Unusual irritability or anger?	☐ Yes ☐ No	Altered sensitivity to light or sound?	☐ Yes ☐ No
Do friends or family seem unfamiliar?	☐ Yes ☐ No	Altered sensitivity to heat or cold?	☐ Yes ☐ No
Unusually intense emotions?	☐ Yes ☐ No	Problems with being in crowded places?	☐ Yes ☐ No
Altered hearing?	☐ Yes ☐ No	Changes in taste or smell?	☐ Yes ☐ No
Changes to appetite or eating habits?	☐ Yes ☐ No	Difficulty organizing tasks or schedule?	☐ Yes ☐ No
Difficulty with speech or swallowing?	☐ Yes ☐ No	Difficulty managing/handling money?	☐ Yes ☐ No

If a person/child has experienced some of these difficulties, the possibility of a brain injury and further cognitive and/or neuropsychological evaluation should be considered.

OTHER OBSERVATIONS OR REMARKS

_____

_____

Does the person/child/child's parent wish to receive additional information about brain injury? ☐ Yes ☐ No

If yes, more information is available from:

Texas Traumatic Brain Injury Advisory Council
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

www.tdh.state.tx.us/braininjury
brain.injury@tdh.state.tx.us
512/458-7111, ext. 3069

Screen Completed By _____ Date _____

Screener Telephone Number _____ (Identification information on reverse)